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### Cover Page Footnote

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# Traversing barriers to health care among LGBTQ+ Latinx emerging adults: Utilizing patient experiences to model access

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## Abstract

Enduring multiple sources of marginalization, lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+) youth of color living at the United States-Mexico border navigate stigma and health challenges surrounding their LGBTQ+ and ethnic identities. This study sought to delineate barriers to health care experienced by marginalized young adult patients. We qualitatively examined the patient experiences of 41 LGBTQ+ Latinx young adults (ages 18-24) in the Rio Grande Valley between 2016 and 2017. Often tied to their experiences of emerging adulthood, most respondents emphasized how financial barriers, including cost of services and disruptions to insurance status, prevented them from seeking care (barriers to care). However, youth also underscored how prior patient experiences tied to their ethnic and LGBTQ+ identities, including apprehension discussing their sexuality with care providers (barriers within care), shaped their health care seeking strategies. This study utilized patient experiences to delineate potential sources of barriers to care experienced by LGBTQ+ Latinx young adults. Practitioners should seek to actively create inclusive and identity-affirming care environments and be sensitive to how prior negative experiences may be deterring young adult patients from seeking care or revealing personal details during the care encounter. If we are to better model access, we need to consider the patient experiences of diverse populations.

## Keywords

Young adults, sexual and gender minorities, LGBTQ+, Latinx, health care access

## Introduction

Access to health care is dependent upon the ability of individuals or groups to receive timely health care services they deem necessary.<sup>1</sup> Relatedly, barriers to care include structural, financial, and personal factors that constrain or prevent individuals or groups from accessing appropriate health care, and therefore utilization.<sup>1</sup> Individuals who occupy multiple minority statuses in the United States, and thus experience multiple marginalization, endure elevated barriers and reduced access to care.<sup>2</sup> Therefore, it is necessary to examine how patient experiences can shape health care access processes. This study contributes to our understanding of health care access by illuminating how care experiences operate for young people seeking and utilizing health care at the intersections of sexual and gender identity, age, and race and ethnicity.

People inhabiting multiple marginalized societal statuses navigate numerous sources of structural oppressions and ensuing inequalities.<sup>3</sup> For example, lesbian, gay, bisexual, transgender and/or queer (LGBTQ+) young adults often encounter prejudice and discrimination that can shape health challenges.<sup>4</sup> LGBTQ+ youth of color broadly endure societal marginalization tied to their multiple intersecting identities, which can harm their health

outcomes<sup>5</sup> and equitable access to care.<sup>6</sup> Specifically, LGBTQ+ Latinx young people have to navigate intersecting marginalization, including anti-LGBTQ+ cultural sentiments as well as racism, citizenship challenges, and language hierarchies, which all combine to shape health disparities.<sup>7</sup> To contextualize the distinctive health care barriers among LGBTQ+ Latinx young people living at the U.S.-Mexico border, and to provide a foundation for establishing LGBTQ+ youth of color-inclusive services, we qualitatively explored the narratives of 41 LGBTQ+ Latinx emerging adults (ages 18-24) surrounding their health care experiences and perceived barriers to care. This study examines the following research question: How do LGBTQ+ Latinx young people living at the US-Mexico border understand their experiences with health services, and what type of structural, financial, personal, or other barriers to care do they identify?

### ***Model for Monitoring Access: Considering Patient Experiences***

Based on The Institute of Medicine's<sup>1</sup> "Model for Monitoring Access," barriers to care can manifest in three forms: 1) *structural*, referring to the health system, such as appointment availability, and their organizational or delivery strategies, 2) *financial*, referring to health care economics, including insurance coverage, costs, and public

or private funding, and 3) *personal*, referring to individual aspects, including cultural background, language, attitudes, and income or education level.<sup>1</sup> These three forms are not mutually exclusive, as *personal* characteristics, such as income, can mediate perceptions of the impact of *financial* barriers. Relatedly, certain *structural* barriers disproportionately influence marginalized individuals, such as LGBTQ+ youth of color.

This study employs the Institute of Medicine's<sup>1</sup> "model for monitoring access" but expands it by demonstrating how multiple marginalized people across LGBTQ+, racial and ethnic, and age statuses, may experience unique barriers (personal, structural, and financial) occurring at multiple, intersecting times. We apply the lens of patient experiences to better consider how perceived barriers *to* care, including barriers preventing initial service access (such as lack of insurance), and experienced barriers *within* care, that is, occurring *during* or *after* a health visit, hinder ongoing access or quality care receipt by patterning access across the health care encounter for multiple marginalized people. Derived from patient narratives, we simultaneously consider *types* of barriers (*structural, financial, personal*), as well as *points* of experienced barriers (barriers *to* or *within*). We anticipate that individuals occupying multiple marginalized statuses are likely experiencing multiple types of health care barriers at multiple points of the care encounter.

### **Multiple Marginalization**

The multiple marginalization framework highlights how individuals occupying subordinated social positions endure *multiple*, intersecting marginalization (i.e. LGBTQ+ people of color) at the personal, interactional, and structural levels, and therefore experience heightened health challenges.<sup>3,8-9</sup> For example, LGBTQ+ young adults of color endure greater "financial" barriers to care, such as diminished insurance coverage.<sup>2</sup> LGBTQ+ youth of color also struggle to access culturally competent services, and often experience multiple forms of health care discrimination.<sup>10</sup> Understanding multiple marginalized groups' health service experiences is critical, as barriers to accessing and within care impact individual health outcomes among LGBTQ+ people of color.<sup>11</sup>

*LGBTQ+ young adults* strongly desire patient-provider relationships grounded in confidentiality, respect, and LGBTQ+-related knowledge,<sup>12</sup> yet they often struggle to access inclusive care.<sup>13</sup> Specifically, LGBTQ+ young adult patients prioritize providers who are explicitly accepting of LGBTQ+ identities, such as validating youths' sexual behaviors, and openness discussing sexual and gender expansiveness.<sup>14</sup> Practitioners who stress binary sex differences or assume heterosexuality uphold medicalized norms that can be perceived as diminishing or erasing LGBTQ+ patient's identities.<sup>15-16</sup> Transgender patients, for example, may avoid seeking out care if they perceive service providers as harboring anti-transgender beliefs.<sup>17</sup>

*LGBTQ+ Latinx young adults'* patient experiences occur at the unique intersection of their gender, sexual, racial/ethnic identities; for example, LGBTQ+ Latinx young adults are more likely to be uninsured (a "financial" barrier) and lack a usual source of care (a "structural" barrier).<sup>11,18</sup> LGBTQ+ Latinx young adult patients may perceive their health care autonomy as constrained when providers dismiss their perspectives due to younger age (i.e., *adulthood*) and when they consistently endure multiple types of identity-based rejection.<sup>19</sup> While providers increasingly undergo cultural-competency training, it is not standardized, and often focused mostly on patients' ethnic or racial identities, rather than being youth-focused or LGBTQ+-affirming.<sup>20</sup>

We build upon previous work examining barriers to care by examining LGBTQ+ Latinx young adults' patient experiences and perceived identity-based health care barriers to and within care at the U.S.-Mexico border. While there is ample evidence that marginalized groups, such as LGBTQ+ people and people of color, endure a myriad of health care challenges, the processes surrounding how they experience and navigate specific barriers have not been fully explored. This study has important implications in promoting more equitable health services by addressing the personal, interpersonal, and structural barriers that impede care utilization and potentially exacerbate health disparities among LGBTQ+ people of color in disadvantaged communities.

## **Methods**

### **Participants**

The study occurred in 2016 through 2017 in the Rio Grande Valley (RGV) in Southernmost Texas, the most economically impoverished region in Texas, with residents disproportionately uninsured.<sup>21</sup> The RGV is an amalgamation of cultures with blended English and Spanish languages, cultural practices, and commerce, and an approximately 90% Latinx, Mexican-identifying population.<sup>22</sup> Largely rural, the RGV has several medium-sized metropolitan areas in which participants resided. There is a paucity of research examining patient experiences in the RGV compared to other border regions (e.g., San Diego/Tijuana), particularly in exploring access to care among multiple marginalized groups.<sup>23</sup> Therefore, additional research is needed to account for population diversity and to meet the health care needs of structurally underserved border communities.

Eligibility required participants to be between 18 and 24 and self-identify as lesbian, gay, bisexual, transgender, queer, or another diverse gender and/or sexual identity (i.e., genderqueer, asexual, pansexual), as well as Latinx as an aspect of their racial/ethnic identity. Exclusion criteria included people who were not U.S. citizens (per institutional mandate) and those who did not speak

English. This age range was chosen based on the critical life course transition from adolescence to young adulthood, termed emerging adulthood, representing a pivotal turning point for young people.<sup>24</sup> The sample was recruited using convenience sampling, supplemented by snowball sampling by handing out optional referral cards with the study contact information to all participants. We recruited participants by posting flyers in community centers such as university commons, coffee shops, and health centers, and by sending listserv emails through local universities. The study was advertised as “a research study exploring lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) Latinx young adults’ health experiences.”

### Procedure

The first author conducted all interviews in English with the consent of participants. Study participants completed one tape-recorded, in-depth face-to-face interview in a private location lasting approximately one hour and a demographic questionnaire. Study procedures were explained to participants and informed consent was obtained prior to the interview. The research team consisted of two white-identified researchers, as well as a Latinx-identifying graduate student, and a community advisory board of Latinx RGV service providers who enhanced the cultural competence of study materials. Participants received \$10 in exchange for their time. All respondents were asked the same series of open-ended questions surrounding their LGBTQ+ and racial/ethnic identities and health. Primary interview example questions included: What has been your experience with health service providers? How do your identities impact your health care experiences? Pseudonyms were used to ensure respondent confidentiality. The university institutional review board approved this study.

All interviews were transcribed verbatim and uploaded into Nvivo 11 for data analysis. We first utilized the method of initial coding to determine emergent categories corresponding with concepts of interest, such as conceptions of sexual, gender, and racial/ethnic identities, and health interpretations.<sup>25</sup> Next, we employed focused coding to center in on the participants’ lived realities from their own perspectives. The final themes emerged inductively from the data. Combined initial and focused coding promotes a constructivist perspective to emphasize the participants’ understandings of their lived experiences.<sup>25</sup> We established inter-rater reliability through a 90% level of agreement in coding, which is much higher than the 70% or greater score recommended for thematic qualitative analyses.<sup>26</sup> In cases of coding disagreement, the authors discussed areas of divergence to determine revisions to our codebook and analytical interpretations.

## Results

### Sample Demographics

Participants’ average age was 21 years old. Table 1 provides descriptive statistics of our analytic sample. Though not asked in the demographics questionnaire, all participants shared that they were either born in the United States or moved there as young children.

**Table 1. Participant Demographics**

	Total (N=41) N (%) or mean (sd)
<b>Age</b>	
Mean (Range = 18-24)	21 (2.27)
<b>Race/ethnicity</b>	
Latino/a or Hispanic	40 (98%)
Multiracial	1 (2%)
<b>Sexual orientation</b>	
Lesbian	8 (20%)
Gay	8 (20%)
Bisexual	16 (39%)
Queer	6 (15%)
Other	3 (7%)
<b>Gender*</b>	
Woman	28 (68%)
Man	12 (29%)
Transgender	2 (5%)**
Other (non-binary)	1 (2%)
<b>Family class status growing up</b>	
Working class	14 (34%)
Middle class	23 (56%)
Upper-middle class	4 (10%)
<b>Employment status*</b>	
Full-time student	34 (83%)
Employed for wages	18 (44%)
Unemployed	6 (15%)
<b>Regional residential context</b>	
Urban	18 (44%)
Rural	23 (56%)

#### Notes

\*Categories not mutually exclusive

\*\*Out of participants who identified as either a woman or a man

Qualitative findings uncovered the varied, intersecting ways that LGBTQ+ Latinx young adults interpreted their experiences with barriers surrounding services they attempted to utilize for health concerns (Table 2). Most emerging adults emphasized how financial barriers, including elevated costs and insurance status, prevented them from seeking care (barriers to care). Also, participants underscored how prior service experiences (barriers within care) constrained their health care seeking

**Table 2. Qualitative Findings Summary**

Themes	Subthemes	Selected Qualitative Quotes
Barriers to Care	Perceived Cost of Care	“My mother had to switch jobs recently so I don’t have any health insurance. If I feel sick I don't know what to do because I can’t afford to go to a doctor. I was in a car accident a while ago and I had to go to the hospital without insurance. It went from around \$1,500 to \$9,000. That's something that I still haven't been able to start paying because I don't have the money.” (Isabel, bisexual Latina woman)
	Lack of Insurance and Insurance Instability	I have bipolar disorder. I used to get treated for it, but I don't have insurance anymore because I turned 19. Every now and then, I do have a mental breakdown or I'm manic or just in my depressive lows, but I know how to keep it under control at times.” (Hector, gay Latino man)
Barriers within Care	Apprehension Discussing Sensitive Topics	“ It’s very awkward at the gynecologist, just because they ask a lot of really personal questions. That's their job, but they are just so specific questions. They ask questions like, "Oh, what are you using for birth control?" or "How many sexual partners have you had?" It just gets really uncomfortable.” (Brianna, lesbian Latina woman)
	Navigating Fear of LGBTQ+ Stigma	“It was so awkward because they were asking about birth control. I was like, ‘I don't use any,’ and they're like, ‘What do you mean?’ I was like, ‘I'm a lesbian.’ I don't know, it's just very weird for a basic check-up, like a physical, so I don't do that anymore. I wasn't out, so they thought I was straight.” (Alejandra, lesbian Latina woman)  “I usually don't go to clinics...nobody wants to talk about the LGBT and what they're doing. It's just more like heterosexual information. If you have sex with a female, this is going to happen. That's one issue I see, is just this invisibility of LGBT anything.” (Eduardo, gay Latino man)
	Intersectional Preference for Affirming Providers	“I think being able to have that in common with your health care provider in general helps a lot. I've seen a psychologist before and he was a white male and I don't have that much in common with white men as far as gender or ethnicity. He was nice but there's that barrier there and I know that individuals who are Latino might feel the same way here in the Valley about health care providers who aren't the same ethnicity as they are.” (Camila, queer Latina woman)

strategies (becoming a barrier to care). Many young people cited personal, identity-based barriers to and within care surrounding apprehension discussing sensitive topics, such as sexual behaviors, which was tied to anxiety disclosing their LGBTQ+ identity. Overall, the LGBTQ+ Latinx emerging adults articulated how processes of multiple marginalization operated in shaping the barriers they perceived to and within health care interactions.

***Barriers to Care: How Experienced and Perceived Financial Barriers Prevent Initial Access to Care***

*Perceived cost of care.* Emotional and mental barriers to seeking out quality health care were formidable burdens endured by LGBTQ+ Latinx young people. Obstacles to accessing services were further exacerbated by participants’ lack of adequate economic resources, notably in terms of insurance coverage. This concern regarding finances in accessing health care is a distinctive structural constraint imposed on emerging adults in particular, as they are often placed in financially precarious positions during the transition away from dependence on their primary

caregivers. Alicia (bisexual Latina) explained her avoidance of seeking out care as connected to the “complicated” and “expensive” nature of insurance in general, and she replied with the following when asked to describe her current health status:

Honestly, I have no idea. I’m supposed to go and find a new doctor, but because of the whole insurance thing, I’ve been a little apprehensive, and I just haven’t bothered. Insurance is so complicated and so expensive; I’ve just let things go.

Additionally, young adults may not view seeking out care as an option because they are still burdened with the hefty cost of utilizing previous health services without insurance, as was the case with Isabel (bisexual Latina):

My mother had to switch jobs recently so I don’t have any health insurance. If I feel sick I don't know what to do because

I can't afford to go to a doctor. I was in a car accident a while ago and I had to go to the hospital without insurance. It went from around \$1,500 to \$9,000. That's something that I still haven't been able to start paying because I don't have the money.

These examples illustrate how insurance status coupled with prior perceived high cost of care shape patient experiences and can bar marginalized young people from accessing services they might otherwise utilize when they lack not only the required financial resources, but also the knowledge resources to successfully navigate the complexities of insurance systems.

*Lack of insurance and insurance instability.* Financial obstacles impacting feeling able to access care were a palpable concern for LGBTQ+ Latinx young adults regardless of their specific health concerns. This barrier, however, can take on more serious forms amid managing a health challenge, and a young person lacks the finances to seek out professional care they deem necessary. The period of emerging adulthood can shape the dynamics of this significant challenge, particularly if a young person loses health insurance coverage once they reach a certain age and no longer qualify to be covered under their parent's plan. Such is the case of Hector (gay Latino), who was diagnosed with a mental health complication but could no longer access care because he independently lacked the financial means:

I have bipolar disorder. I used to get treated for it, but I don't have insurance anymore because I turned 19. Every now and then, I do have a mental breakdown or I'm manic or just in my depressive lows, but I know how to keep it under control at times.

Hector further elaborated that he desired to secure insurance in the future, but was unable to because of his college student status, as well as his precarious employment: "I'm planning on getting insurance, I just can't right now because I'm a student and I work part-time, so I don't really qualify for insurance." Hector's narrative is especially striking in that during a formative period of his life, as an emerging adult college student, he is forced to manage his mental health disorder on his own in the absence of any type of structural support simply because he "turned 19."

While lacking health insurance was a primary reason for LGBTQ+ Latinx young adults felt unable to access care, other participants also discussed the steps they took to address their own health concerns through more informal means, such as self-regulation of health and health information sources. Marco (gay Latino) explained his

dedication to staying healthy and avoiding the necessity of formal care:

Since I don't have insurance, it's kind of hard for me to go to the doctor all the time. That's another reason I try to be safe, I just get tested a lot. I try not to get sick as often or put myself in spots where I know I'm going to get a cold or something, because then I'm susceptible to other stuff.

In a similar way, Nadia (lesbian Latina) described the steps she took to address her own health concerns in the absence of structural health care access:

I get scared, you know. I want to check if I'm okay, because I don't have the insurance so I check on Google if I'm okay, like check out the symptoms. Or I try to go buy some medicine before it escalates.

The stress of economic considerations within health management takes its toll and can make youth feel "scared" about their health outcomes. These examples underscore how perceived financial constraints bar potential Latinx and LGBTQ+ patients from access, indicating that patient experiences should be contextualized beyond the physical walls of the health care institutions. Highlighting the strain of economic barriers to care on young people, Gabriela (bisexual Latina) articulated:

It's nerve-racking because what if there is something that's going on down there, and I'm paranoid about it, but I can't go get it checked out because I don't have the money.

Young adults' emphasis on taking personal charge of their health when they lacked financial resources places the onus of responsibility for health management on the marginalized young person, rather than societal structures that should support population health.

### ***Barriers within Care: How the "Personal" Becomes "Structural"***

*Apprehension discussing sensitive topics.* The challenges LGBTQ+ Latinx young adults faced in seeking out services varied across how participants perceived their identities (age, gender, sexuality, race and ethnicity), and some young people avoided these challenges altogether if they viewed obstacles as seemingly insurmountable. Participants often discussed enduring significant anxiety about discussing sensitive issues, as well as the fear of potentially learning about a potential health complication. Katia (lesbian Latina) illuminated this process in describing why she avoids seeking out professional health care and how this fear caused her distress:

It's a new thing that I am not exposed to, and talking about my vagina, I mean I know the things, the basic things about the vagina. But the frightening part is just another human being that you really don't know checking in there. It just goes through my mind, imagine if they find something...It's just frightening, even to go to the doctor. It's just like, oh I don't want to see if I have something.

The debilitating fear described by Katia can pose a significant barrier to and within care for emerging adults who may lack experience independently seeking out health services or have yet to find an inclusive practitioner.

An additional barrier to seeking out care involved their anxiety in broaching topics they deemed uncomfortable, which often related to personal ideologies surrounding contentious social topics. Furthermore, young people had to navigate the challenges of socially sensitive and taboo topics that hinged on their multiple, intersecting identities, which ultimately shaped more strain for them within care experiences. Adrianna (queer Latina), for example, expressed her mental distress in perceiving her religious views (tied to being Latina from a predominantly Catholic region of the U.S.) to be incompatible with her therapist's opposing perspective, which led her to consider avoiding treatment altogether because she feared judgment:

I just felt since he was atheist and I wanted to talk about certain spiritual things that I felt if I went into session with him, he has more of a challenge understanding my beliefs in general. I just didn't feel like it was completely non-judgmental. You don't want to be labeled as psychotic. Or delusional. That's a concern. Having that in the back of my mind made me not want to go.

In a similar way, Brianna (lesbian Latina), expressed concern with her sexual and reproductive health service experiences and how a provider's probe into her sexual behavior history posed a personal barrier within care to her comfort:

It's very awkward at the gynecologist, just because they ask a lot of really personal questions. That's their job, but they are just so specific questions. They ask questions like, "Oh, what are you using for birth control?" or "How many sexual partners have you had?" It just gets really uncomfortable.

From these examples, marginalized youth strongly desire services they deem critical to their health, but they are also hyperaware of how a medical professional's potential

biases, such as tied to religiosity or sexuality, might detract from the quality of care they desire.

*Navigating fear of LGBTQ+ stigma.* A young person's avoidance of attempting to access care may be tied to not only their apprehension surrounding a particular distressing diagnosis or discussing a sensitive topic, but this anxiety could also be related to a fear of identity-related prejudice and discrimination surrounding youth's LGBTQ+ and/or Latinx identities. For example, Miguel (bisexual transgender Latino) outlined his avoidance of seeking out a general health care provider because he had anxiety about explaining his LGBTQ+ identity to an unaccepting health professional:

I recently got a yeast infection. I put off going to the doctor for about three months, because I just Googled my symptoms, and Googled, and Googled, and tried different things, just so I could avoid that. I mean, I'd have to explain everything, and who knows how they would react. To overcome that challenge, I feel like I could reach out to my support group, and maybe see if they've had any good experiences with doctors.

A young person's fear of anti-LGBTQ+ prejudice and discrimination, notably anti-transgender beliefs, may be a major health detriment if at-home treatments are insufficient. Furthermore, LGBTQ+ Latinx emerging adults may feel particularly limited in their health care options when they must perform the labor of seeking out inclusive care on their own when structural constraints often fail to provide widely accessible LGBTQ+-centered services.

In many cases, an emerging adult's previous experiences of stigmatizing barriers within care prompted them to forego seeking out care for future health challenges when they wanted to avoid additional stigma. For Eduardo (gay Latino), navigating fear of stigma shaped his avoidance of utilizing clinics that he perceived to be unaccepting of LGBTQ+ people:

I usually don't go to clinics...nobody wants to talk about the LGBT and what they're doing. It's just more like heterosexual information. If you have sex with a female, this is going to happen. That's one issue I see, is just this invisibility of LGBT anything.

The systemic "invisibility of LGBT" within health care services was echoed by Alejandra (lesbian Latina):

It was so awkward because they were asking about birth control. I was like, 'I don't use any,' and they're like, 'What do you mean?' I

was like, 'I'm a lesbian.' I don't know, it's just very weird for a basic check-up, like a physical, so I don't do that anymore. I wasn't out, so they thought I was straight.

These exemplars demonstrate how LGBTQ+ Latinx youth can endure health care norms that privilege heterosexuality by erasing LGBTQ+ identities, and how providers can also reinforce these norms through interactions that assume heterosexuality. As a result, marginalized youth may be deterred from seeking out services after experiencing significant barriers to care wherein practitioners invalidated their LGBTQ+ identities.

*Intersectional preference for affirming providers.* LGBTQ+ Latinx emerging adults emphasized how their racial and ethnic identities could shape their health care experiences, and potentially impact barriers within care. Such is the case of Camila (queer Latina), who described how she desired shared intersecting racial, ethnic, and gender identities with her service provider to enhance her care:

I think being able to have that in common with your health care provider in general helps a lot. I've seen a psychologist before and he was a white male and I don't have that much in common with white men as far as gender or ethnicity. He was nice but there's that barrier there and I know that individuals who are Latino might feel the same way here in the Valley about health care providers who aren't the same ethnicity as they are.

From Camila's narrative, inclusive care can embody the dynamic of shared social statuses between a provider and a patient to make individuals more comfortable in an interaction, as well as mitigate the potential for navigating identity-based stigma. This preference for similar providers shows how it can be critical for LGBTQ+ Latinx young people to experience affirming care across their multiple, intersecting identities rather than a singular identity they hold.

## Discussion

Findings from this study can provide a foundation for utilizing the individualized patient experiences of multiple marginalized populations, such as LGBTQ+ Latinx young adults, to address public health structural inequalities within health care services. Employing the Institute of Medicine's<sup>1</sup> "model for monitoring access" through a patient experience lens, this study demonstrates that barriers can occur at two points; first, LGBTQ+ Latinx young adults experience both barriers *to* health care, which included predominantly "financial" barriers, and secondly, and barriers *within* health care, including "structural" and what has previously been deemed "personal".<sup>1</sup> Taken

together, these findings demonstrate how both financial barriers and perceptions of potential discrimination and apprehension regarding medical care are important processes in understanding how multiple marginalized emerging adults are constrained in their health endeavors. Patient narratives suggest that so-called "personal" barriers (LGBTQ+ identity, Latinx background, and age) are indeed "structural" barriers perpetuated by heterosexism, ageism, and classism patterned in typical health care encounters. We found that young people's conceptions of their marginalized statuses linked to health care challenges highlight how the personal becomes "structural" in shaping access to and experiences within care. Therefore, our findings are critical in informing services and policies towards more equitably accessible health care, as well as more positive care experiences for marginalized populations. By considering identities like LGBTQ+ and racial/ethnic status as "personal," health care institutions may ignore how they are operating in a way that exacerbates access disparities; that is, institutionalized health care bias toward individuals for their "personal" characteristics acts as a structural barrier.

Young people largely endure barriers to accessing health care related to financial need and rising costs,<sup>27</sup> as well as identity-based stigmas.<sup>28</sup> While insurance is often framed as "external" to patient experiences within the health care setting, practitioners should consider how financial barriers, including insurance status, are a fundamental element shaping the patient care experience.<sup>29</sup>

Emerging adulthood can be an especially challenging time for navigating personal finances, particularly as young people develop beyond families of origin, such as attending college or securing jobs.<sup>24,30</sup> Health insurance was a stressor for young people in this study, demonstrating the need for resources providing affordable health care for young adults. Transitioning to adulthood, many emerging adults lose health insurance coverage,<sup>31</sup> and LGBTQ+ youth, including LGBTQ+ Latinx youth, are more likely to have strained family relationships that could disrupt their access to parental insurance.<sup>32-33</sup> While the Affordable Care Act increased access to financial supports for young people,<sup>27</sup> our study highlights how marginalized Latinx youth are still struggling to secure health insurance. While cost and insurance are barriers to care experienced by many U.S. residents, the Rio Grande Valley area of Texas has the highest uninsured rates in the U.S., with an estimated 32% of the community living without health insurance.<sup>21</sup> Our study suggests that more attention should be given to multiple marginalized young people who may benefit from insurance coordination and resources found in some primary care clinics.<sup>34</sup>

In addition to significant financial barriers to accessing care, LGBTQ+ emerging adults also encounter barriers in securing quality, affirming services, such as fear of stigma

and heterosexist provider norms.<sup>35</sup> Many participants emphasized “personal” concerns, such as fear discussing sensitive topics and stigma that transformed into structural barriers, which prompted some youth to avoid seeking out care in the future after having a negative provider experience. Indeed, LGBTQ+ young adults of color may be especially constrained in accessing health care services if they are rendered invisible or pathologized.<sup>28</sup> Marginalized across their youth status and race and ethnicity in health care settings,<sup>36</sup> in combination with managing anti-LGBTQ+ stigma,<sup>2</sup> LGBTQ+ Latinx emerging adults endure multifaceted barriers within care. Based on participants’ narratives explicating the inadequacies of institutionalized health care and their decisions to self-treat or forego care, service providers and policymakers should acknowledge marginalized youth’s experiences to be supportive of individual health needs.

Health care providers can address barriers *within* care by creating services that are culturally competent, LGBTQ+-affirming, and youth-centered. Approximately 20% of 18-34-year-olds identify as LGBTQ+,<sup>37</sup> and institutionalized health care must start actively considering its role in meeting their unique health care needs and engaging them in health services.<sup>38</sup> As participants indicated that discussing sensitive topics with providers, such as sexual health, can be challenging, providers should educate themselves on LGBTQ+ identities and practice inclusivity.<sup>14</sup> Negative patient-provider interactions impact health care decision making, with youth in this study reporting that they avoid health care due to perceptions that they are not accepted.

Young people often appreciate a provider initiating LGBTQ+-affirming discussions of sexual health,<sup>39</sup> and this practice can greatly enhance marginalized young people’s access to and experiences within care. Providing young people with more options for service providers can also improve marginalized youth’s experiences, particularly if they prefer practitioners who share their social statuses because they perceive them as more empathetic. Furthermore, more positive health service experiences among LGBTQ+ Latinx young adults could promote the development of resilience and strengths-based resources to offset adverse life challenges within LGBTQ+ communities of color.<sup>40</sup> Emerging adulthood is a critical time to establish trust in institutions, with long term implications for young people’s health trajectories, and a critical step health providers can take is validating young people’s diverse health concerns.<sup>41</sup>

This study makes important contributions to understanding processes of barriers surrounding health care for marginalized emerging adults, yet there remain limitations. First, LGBTQ+ Latinx emerging adults were recruited using convenience-sampling methods, which may constrain our findings’ generalizability. Though this study

presented the narratives of two transgender Latinx men, future work should expand on transgender youth of color’s barriers to care, as they often endure distinctive financial and stigmatizing challenges.<sup>10</sup> Additionally, the cross-sectional nature of data collected in a single interview restricts the scope of patient experiences and how they may shift across emerging adulthood. Finally, although this study’s qualitative focus underscores the need to strive for equitable access to health care for marginalized young adults, future research should also quantitatively assess diverse patient population experiences.

## Conclusion

The unique regional context of this study is integral in shaping participants’ interpretations of their experiences, as well as the time period of data collection from 2016-2017 when Donald Trump was elected president and worked to promote xenophobic, anti-immigrant rhetoric and policies. The Trump presidency heightened feelings of marginalization, fear, and anxiety among targeted marginalized groups such as Latinx young people,<sup>42</sup> which can further shape intersectional systemic and individual healthcare inequalities. The Rio Grande Valley has limited access to affordable health services,<sup>43</sup> and is one of the most economically depressed areas in Texas. This study makes important contributions to understandings of health care access among multiple marginalized border residents. Institutionalized health care must be examined from marginalized individuals’ perspectives to determine potential health care barriers, and how care can be improved to provide inclusive, accessible services. For marginalized groups, health care barriers can occur while seeking out care, as well as during experiences of care. Therefore, acknowledging the dynamic ways that young people’s marginalized statuses across age, race, ethnicity, gender, and sexuality intersect to shape obstacles to and within care is critical in establishing a more holistic understanding of emerging adults’ health care experiences as patients. Promoting diverse and expansive health care structures and practices has the potential to reform health systems to explicitly focus on improving population health among all groups, including those who are socially marginalized and underserved.

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